Washington State Department of
Labor & Industries

Work Rehabilitation Application

PO Box 44324
Olympia WA 98504-4324

Instructions:

This application is for therapy clinics who are seeking to be an approved work rehabilitation (WR) location.

Submit a separate application for each clinic location. You must complete Sections A – E.

You must also attach the following:

- Floor plan – identify dedicated and shared area for use in the WR program.
- Quality Assurance Materials / Handouts
- Program Manual

You must also include the following documentation examples:

- Initial Evaluation and Care Plan
- Progress Report
- Weekly Care Conference Note
- Daily Note

No later than December 31, 2023, complete and submit clinician training requirements in Appendix B.

If you have any questions about this application, please contact us at 360-902-5481 or email us at Therapy@Lni.wa.gov.

Submit your completed application via fax to 360-902-5035 or via email at Therapy@Lni.wa.gov.

Part A – Application Type

I am applying to become a work rehabilitation (WR) provider:

☐ Work Rehabilitation – Conditioning Clinic Only (up to 4 hour program)

☐ Work Rehabilitation – Conditioning ***and*** Work Rehabilitation – Hardening Clinic (up to 8 hour program)

Part B – Clinic Information

1. Business Information

Clinic Name	L&I Group Provider Number for Location
Name of Primary Contact	Clinic Email Address

2. Clinic Location Address

Street Address		
City	State	Zip Code
Clinic Phone Number	Clinic Fax Number	

3. Type of Program

- ☐ Physical and Occupational Therapy Clinic
- ☐ Physical Therapy (PT) Only Clinic
- ☐ Occupational Therapy (OT) Only Clinic

4. Identify any specialty jobs you are set up to simulate (i.e. outdoor space, driving simulator)

5. Do you have existing relationships with your community healthcare/behavioral health professional? (Providers you have collaborative referral relationships with to include behavioral health providers)

- ☐ Yes
- ☐ No – please provide me with resources

6. List any additional services other than work rehabilitation (WR) you offer at this location

Part C – WR Program Elements

Check each box to indicate your program has been updated to meet these program requirements.

1. Initial Comprehensive Evaluation

Requirement	Met
Medical history	☐
Self-report questionnaires / functional outcome measures	☐
Musculoskeletal screen	☐
Fitness level	☐
Material handling	☐
Positional tolerance	☐
Baseline comparison for return to work demands	☐
Psychosocial barriers	☐
Customized approach	☐

2. Functional Job Description / Analysis

Requirement	Met
Available at the time of the evaluation	☐
Consensus from worker about job demands of the job goal	☐

3. Individualized Plan of Care

Requirement	Met
Goal aligned with return to work plan	☐
Established using therapeutic alliance	☐
Goals signed by worker and therapist	☐
Includes work simulation / focus on functional abilities	☐
Timely communication with stakeholders to develop plan	☐
Recommended intensity choice and frequency / duration explained	☐

4. Full Body Conditioning Program

Requirement	Met
Strength, conditioning, and flexibility levels quantified and recorded	☐
Standardized method used	☐
Progressive design based on frequency, load, and duration	☐
Modified based on condition / comorbidities	☐

5. Work-Based Tasks / Simulation

Requirement	Met
Progressive design based on frequency, load, and duration	☐
Job demands simulated as closely as able	☐
Worker’s job-specific tools used when feasible	☐

6. Participatory Ergonomics

Requirement	Met
Worksite assessed to identify adjustments / task progression of the job to allow modified / full duties	☐
Collaborate with worker / vocational counselor / employer	☐

7. Behavioral Interventions

Requirement	Met
Principles applied for workers with psychosocial barriers to return to work	☐
Interventions are aligned with workers’ preferences and values	☐
Resources identified and initiated when needed	☐

8. Client Education

Requirement	Met
Topics include: pain neuroscience, self-management, pacing, posture, body mechanics, safety, injury prevention, wellness (stress management, dietary/lifestyle changes)	☐

9. Team Care Conference / Progress Updates

Requirement	Met
Occurs every two weeks	☐
Invitations to care team (VRC, AP, other)	☐
Discuss capacity level, progress, barriers, updates to outcome measures, changes to care plan / home program / treatment approach, and assign roles	☐
Includes return to work transition plans or safe progression of work duties if working	☐

10. Collaboration with Stakeholders

Requirement	Met
Ongoing communication built into program at regular intervals and when barriers arise	☐

11. Discharge

Requirement	Met
Comparison of baseline and final physical demand capacity levels	☐
Treatment concluded when goals met or progress has plateaued	☐
Final transitional work plan or safe progression of work duties in place	☐
Individualized home program finalized	☐

Part D – Quality Assurance (QA) Program

Describe your standardized quality assurance program framework and how you will evaluate at the individual, therapist, and program level. Make sure to include the roles of who is involved, how it is reported, how often, and how it informs your program improvements.

Part E – Work Rehabilitation Program Agreement

Statement of Agreement

I intend to follow Department of Labor & Industries (L&I) laws, rules, and requirements while providing work rehabilitation services.

I attest all treating providers will have completed all of their L&I required training by December 31, 2023. Any new provider after this date must have their training completed before treating clients in a work rehabilitation program.

I will submit Appendix B to L&I by December 31, 2023 and understand training records may be audited.

I will ensure required paperwork is submitted timely to L&I and the attending provider.

- Initial Evaluation / Plan of Care within 5 business days.
- Progress Summaries and Discharge Capacity Summary within 7 business days.
- Daily treatment notes within 30 days of program ending.

Clinic Owner / Manager Name	Title	Date

Clinic Owner / Manager Signature

Appendix A: Provider Education & Training Requirements

Category	Minimum # of Hours	Subtopics
A. L&I Workers Compensation Basics for Physical Medicine Providers	2	• Job analysis / job description • Ergo / modifying jobs • Vocational recovery • Worker disability prevention • Employer incentive program • Abbreviations / terminology
B. Pain Neuroscience Education	2	• Basic Principals • Resources / Tools
C. Psych-Informed Practice	2	• Biopsychosocial model of care • Motivational interviewing • Self-management / cognitive behavioral therapy – restructuring beliefs and promoting adaptive behaviors • Acceptance and commitment therapy (ACT) • Therapeutic alliance
D. Physical Med Best Practices	2	• Functional goal setting • Patient expectations • Lifestyle and health advice • Psychosocial barrier support • Graded activity • Graded exposure

Training required every 6 years on the same date clinician's Washington license is renewed. Training must be within the 6-year cycle.

Appendix B: WR List of Clinicians

List each individual clinician providing WR services and the date their required education and training was completed.

Name of Clinic	Location City

Clinic Owner / Manager Signature

Date

Clinician's Name (Last, First, Middle Initial)			
Provider Type (OT, PT, COTA, PTA, ATC)	Individual NPI Number	L&I Individual Provider Number (if applicable)	WA License Expiration Date
Training A – Workers Comp Basics Completion Date	**Training B – Pain Neuro Completion Date**	**Training C – Psych-Informed Completion Date**	**Training D – Best Practices Completion Date**

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